IN THE HIGH COURT OF GUJARAT AT AHMEDABAD

LETTERS PATENT APPEAL No 1028 of 2003

with

LETTERS PATENT APPEAL No 1003 of 2003

with

LETTERS PATENT APPEAL No. 1004 of 2003

with

SPECIAL CIVIL APPLICATION NO. 9425 of 2002

For Approval and Signature:

HON'BLE MR.JUSTICE R.K.ABICHANDANI
and
HON'BLE MR.JUSTICE D.A.MEHTA

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1. Whether Reporters of Local Papers may be allowed to see the judgements? : YES

2. To be referred to the Reporter or not? : YES

3. Whether Their Lordships wish to see the fair copy of the judgement? : NO

4. Whether this case involves a substantial question of law as to the interpretation of the Constitution of India, 1950 of any Order made thereunder? : NO

5. Whether it is to be circulated to the concerned Magistrate/Magistrates,Judge/Judges,Tribunal/Tribunals? : NO

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1. LETTERS PATENT APPEAL No. 1028 of 2003

UNITED INDIA INSURANCE COMPANY LTD.

Versus

MOHANLAL AGGARWAL

Appearance:
MR RAJNI H. MEHTA, Advocate for Appellant
MR NAVIN K. PAHWA, Advocate for Respondent

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2. LETTERS PATENT APPEAL No. 1003 of 2003

UNITED INDIA INSURANCE CO. LTD.
Versus
PRAVIN B. NANAVATI

Appearance :
MR P.V. NANAVATI, Advocate for Appellant
MR B.I. MEHTA FOR MR AMIT C NANAVATI Advocate for the Respondent

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3. LETTERS PATENT APPEAL NO. 1004 of 2003

UNITED INDIA INSURANCE CO. LTD.
Versus
MANUBHAI DHARAMSINHBHAI GAJERA

Appearance :
MR P.V. NANAVATI, Advocate for the Appellant
MR B.M. MANGUKIA, Advocate for the Respondent No.1
MR S.N.SHELAT, ADVOCATE GENERAL with
MS. MEGHA JANI, Advocate for the Respondent No.2

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4. SPECIAL CIVIL APPLICATION NO. 9425 OF 2002 :

CONSUMER EDUCATION & RESEARCH SOCIETY & ORS.
Versus
NEW INDIA ASSURANCE CO. LTD.

Appearance :
MR.A.J.PATEL, Advocate for the Petitioners
MR.P.V.NANAVATI, Advocate for the Respondent No.1
MR.S.N.SHELAT, ADVOCATE GENERAL WITH
MS.MEGHA JANI, Advocate for the Respondent No.2

CORAM : HON'BLE MR.JUSTICE R.K.ABICHANDANI
and
HON'BLE MR.JUSTICE D.A.MEHTA

Date of decision: 05/12/2003

ORAL JUDGEMENT

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(Per : HON'BLE MR.JUSTICE R.K.ABICHANDANI for the Court)

1. These three Letters Patent Appeals have been directed against the judgement and order of the learned Single Judge passed on 8th August 2003, allowing the three petitions from which these appeals arise, while the Special Civil Application No. 9425 of 2002 has been filed for a direction on the respondents - insurance companies not to exclude the diseases contracted by the petitioner No.2 during the period of mediclaim policy, which was renewed from time to time, and not to load the premium, as was sought to be done, and to renew the mediclaim policies of the petitioner No.2 and 3.

2. All the matters relate to mediclaim insurance policy and revolve around the question, whether the insurer has absolute right to cancel the contract of mediclaim insurance or to refuse renewal of the mediclaim policy and have been argued together by the learned counsel appearing for all the parties.

Brief Facts and Pleadings :

3. The Letters Patent Appeal No.1028 of 2003, which arises from Special Civil Application No.11844 of 2002, in which a direction was sought for setting aside the action of the insurer (United India Insurance Co. Ltd.) in seeking to exclude certain diseases as per the communication dated 3rd October 2002 addressed by the Divisional Manager of the insurance company to the insured, as illegal, arbitrary, unreasonable and violative of Article 14 of the Constitution. A direction was sought on the insurer to renew the mediclaim policy with effect from 3rd October 2002 and to settle all the claims of medical dues covered by the insurance company as per the terms of the existing insurance policy.

3.1 In that case, the petitioner had applied for a mediclaim insurance policy for the first time in 1990 for a sum of Rs.90,000=00. The sum insured under the policy

was thereafter revised to Rs.3 lakhs from 1993-94. The policy was being renewed from time to time on the regular payment of the premium amount by the insured and was lastly renewed on 4th October 2001. The insured requested for a further renewal by his letter dated 9th September 2002 forwarding the banker's cheque of the premium amount to the insurer, which was well ahead of the date of 3rd October 2002 on which the existing policy was to end. A reminder was sent by the insured on 17-9-2002 requesting the insurer to renew the policy, followed by a legal notice dated 27-9-2002. Thereafter, on 30th September 2002, the insurer addressed a letter to the insured that, due to "high claim experience", the policy will be renewed by loading of 300% premium and the insured was accordingly required to issue a cheque for the revised premium. The insured accordingly deposited the amount of the revised premium by cash on 1-10-2002 being 300% premium for which a receipt was issued by the insurer on 1-10-2002. The regular premium as well as extra premium were thus paid by the insured in time i.e. before the end of the term of the existing policy. However, thereafter, on 3rd October 2002, the insurer issued a letter on the insured to the effect that the policy could be renewed only subject to the exclusion of five diseases. The major diseases against which the insured was covered were sought to be excluded from the policy. According to the insured, he was 65 years of age and needed coverage of mediclaim the most, because of his chronic renal failure, and, the action of the insurer seeking to exclude all major diseases from the coverage was arbitrary and illegal and not befitting a Government of India Company, which was created for the public and social welfare.

3.2 The insurer contested the petition by filing affidavit-in-reply dated 25th December 2002 contending that the insured was not entitled to get the mediclaim insurance policy renewed without the exclusionary clause in view of the stipulation in clause No.5.9 of the policy, as per which, the policy may be renewed by mutual consent and the company may at any time cancel the same by sending the insured a thirty days' notice and refunding the prorata premium for the unexpired period. According to the insurer, the policy cannot be renewed without mutual consent and the extraordinary jurisdiction of the High Court cannot be invoked in getting it renewed. It was further contended that the mediclaim policy which was issued by the insurance company was "not statutorily required and, therefore, there is no legal right and obligation between the Company and the petitioner". It was also submitted that there was

nothing arbitrary in refusing to renew the policy, and that the decision of the Apex Court in Biman Krishna Bose v. United India Insurance Company Ltd., reported in 2001 (6) SCC 477, was not applicable to the case, because, the question that the policy could be renewed only by mutual consent did not arise in that case and that the monopoly as regards the general insurance business did not now remain with the companies. It was also contended that the condition of the insured was a chronic condition requiring dialysis at least four times in a month and the suggestion implied in his letter dated 2nd October 2002 that dialysis would continue till the end of October 2002 as opined by the doctor, amounted to making of a false statement for getting the policy renewed. It was submitted that the insured was financially very sound and had a roaring business and therefore, the statement that he was unable to make both ends meet was false. It was also pointed out that, in the past, the claims of the insured for Rs.80,000=00 for heart surgery in the year 1994, for Rs.60,000=00 for T.B. treatment in the year 2000 and for Rs.2,05,000=00 for kidney failure treatment in the year 2002, were paid by the insurer. It was further contended that now the diseases contracted by the insured were undisputedly known and in such circumstances, the element of "unforeseen event or occurrence" had ceased to exist and therefore, the insurance being essentially an agreement whereby the insurer agrees to indemnify the person insured against an unforeseen event, the insured was not entitled to get the insurance of such diseases which were by now known.

4. In Letters Patent Appeal No.1003 of 2003, which arises from Special Civil Application No.8516 of 2003, the insured sought a direction on the insurer (United India Insurance Company Ltd.) to renew his mediclaim policy challenging its refusal to renew the same. The insured had obtained a mediclaim insurance which was renewed continuously for a period of eight years, lastly for the period from 15-12-2001 to 14-12-2002, as stated in paragraph 3 of the petition. The insured was required to undergo heart surgery and had put up the claim under the policy which was paid. However, thereafter, when the insured requested for renewal of the mediclaim policy for a further period of one year and also sent a cheque of the due amount of premium, the insurer, by letter dated 2nd December 2002, cancelled the policy. The insurer again by letter dated 13th December 2002 took up a stand that renewal of the policy was dependent upon the discretion of the company, and that it did not want to renew the policy. By letter dated 21st February 2003, the insurer informed the insured that, his request was

refused and that he should not address further letters to the company which will not be replied.

4.1 In the affidavit-in-reply dated 7th July 2003 filed on behalf of the insurer, the insurer contended that it had fulfilled its obligations under the existing policy, which ended on 14-12-2002, and that each mediclaim policy provides that policy can be renewed by mutual consent of all the parties. It was contended that one cannot insist for underwriting for medical insurance till the insured remains alive. It was also contended that the general insurance business was nationalized in the year 1972 from 2nd January 1973 and the General Insurance Corporation of India was to carry out its objectives under Section 9 of the Act. The Act of 1972 bestowed an exclusive privilege to operate, on the four nationalized insurance companies. However, the exclusive privilege was taken away by virtue of the provisions of the Indian Regulatory and Development Authority Act, 1999, which came into force from December 29, 1999, by insertion of Section 24A in the Act of 1972. It was submitted that an insurance policy being in the realm of the contract, renewal could not be sought except by mutual consent. Moreover, the term "insurance" as defined in Black's Law Dictionary, indicated that insurance is a type of contingency contract and it was not in the nature of an annuity. It was submitted that the insurer had a legal right to regulate its business and its business wisdom was not justiciable. Reliance was placed on the decision of a Division Bench of this Court rendered on 31st July 1995 in Special Civil Application No.3628 of 1995 in paragraph 9 of the affidavit-in-reply, in which it was held that no mandamus can be issued directing the State to frame a policy in a particular way and that the scheme of mediclaim did not expressly include the case of a mentally retarded person. The decision of the Apex Court in General Assurance Society v. Chandmull Jain, reported in AIR 1966 SC 1644 was referred in paragraph 11 of the affidavit-in-reply, for contending that the condition in the insurance policy giving mutual rights to the parties to terminate the insurance at any time cannot be read as a right to terminate for a reasonable cause. The Supreme Court held that, where the party agrees upon certain terms which were to regulate their relationship, it was not for the court to make a new contract, however reasonable, if the parties have not made it for themselves.

5. In Letters Patent Appeal No.1004 of 2003, which arises from Special Civil Application No.1128 of 2002, the insured had challenged refusal to renew the mediclaim

insurance policy by the communication dated January 16, 2002 sent by the insurer. The insurer had refused to renew the mediclaim policy stating in its letter dated 16-1-2002, at Annexure "D" to the petition: "We have to inform you that we are not interested to renew your above policy". According to the insured, the action of the insurer, which was "State" within the meaning of Article 12 of the Constitution, is arbitrary and violative of the fundamental rights of the insured guaranteed by Articles 14 and 21 of the Constitution.

5.1 In the affidavit-in-reply dated 26-4-2002 filed by the insurer (United India Insurance Company Ltd.), it was contended that the decision to refuse renewal taken by the insurer was in the course of the business of the company and therefore, not amenable to the writ jurisdiction of this Court. Reliance was placed on condition No.5.9 of the policy, as per which, the policy may be renewed by mutual consent, contending that there was no obligation on the insurer to renew the policy. It was contended in paragraph 6 of the reply that since the general insurance business was no longer a monopoly of the General Insurance Corporation and its subsidiary Companies, the cases decided earlier on the footing that the four insurance companies were the only statutory bodies who could undertake the business of general insurance now no longer apply, and that the decision of the Supreme Court in General Assurance Company Ltd. v. Chandmull Jain (supra) was applicable.

6. In Special Civil Application NO. 9425 of 2002, which was filed by the Consumer Education and Research society and two insured persons for a direction on the respondent No.1 (New India Assurance Co. Ltd.) not to exclude the diseases contracted by the petitioner No.2 during the period of the policy which had been renewed from time to time and not to load the premium; and to include the diseases and renew the policy including such diseases, and, a direction on the respondent No.2 (National Insurance Co. Ltd.) to renew the policy of the petitioner No.3, setting aside the refusal in its letter dated 15-1-2002 made on the ground of "adverse claim ratio".

6.1 The insured - petitioner No.2 had taken mediclaim insurance for himself, his wife and other family members continuously from the year 1992-93 and was regularly paying the premiums from time to time. In August September 1999, he was admitted twice in the hospital for high grade fever and was diagnosed as having acquired Hypogamaglobulinemia. The mediclaim policy, which was

last renewed, was valid upto 13th August 2002. On 26th July 2002, the said insured was informed that his mediclaim policy will be renewed subject to the exclusion of the disease "Septicemia with Hypogamaglobulinemia" and was advised that his next premium will be accepted with loading of 100% with 5% excess for each and every claim.

6.2 The insured (petitioner No.3) was having mediclaim and accident policies since 1988 with the insurer and had renewed the same from time to time. His mediclaim policy was expiring on 6-2-2002 and he therefore paid renewal premium by cheque on 7-1-2002 which was debited from his account on 9-1-2002. However, by letter dated 15-1-2002, he was informed by the respondent No.2 that, after going through the record, it had decided not to renew his policy, advising him to renew his policy with some other insurance company. It was contended that the respondents were `State' within the meaning of Article 12 of the Constitution and that, their action of excluding the diseases acquired during the period of the cover while renewing the policy, was arbitrary, unfair and violative of Article 14 of the Constitution. It was also contended that the refusal to renew the mediclaim policy on the ground of high claim ratio after having accepted the premium was also arbitrary, unfair and unjustifiable at law. Reference was made to Section 9 of the Health Insurance Act, 1994 of Ireland to illustrate that a registered undertaking was restrained thereunder from terminating or refusing to renew a health insurance contract without consent of the other party. Reliance was also placed on a circular-letter dated 18-12-1998, at Annexure "I" to that petition, of the National Insurance Company Ltd., showing the directions issued on the basis of the General Insurance Corporation Circular dated 13th June 1988, which required that in case of renewal without a break in the period, the policy was to be renewed by including the diseases contracted during the period of expiring policy.

6.3 In the affidavit-in-reply dated 25th November 2002 filed on behalf of the respondent No.1 insurer, a stand similar to the one taken in the affidavit-in-reply filed in the other petitions, which are referred to hereinabove, has been taken, and it was contended that the policy decision was taken not to renew the cover, which was in the realm of business and was, therefore, not a justiciable issue. A copy of the prospectus of the mediclaim insurance scheme and a mediclaim policy was produced with the said affidavit-in-reply, at Annexure "J" to the petition and it was contended in paragraph 10(d) that : " ..... the annual contract of renewal

is with mutual consent as per the prospectus and also policy."

6.4 In the affidavit-in-reply dated 2nd December 2002 filed by the respondent No.2 - insurer also, similar contentions, as were raised by the insurer in the other petitions, are raised and are, therefore, not repeated. It is, however, contended that the action of the respondent No.2 in refusing to renew the mediclaim policy of the petitioner No.3 was as per its business policy. It was stated that the guidelines in the circular-letter at Annexure "I" was an internal correspondence between the two offices of the respondent No.2 and the insured cannot claim any relief on the basis of such correspondence. A copy of the mediclaim (individual) insurance policy (revised) is annexed at Annexure "A" with the said affidavit-in-reply.

6.5 In the rejoinder filed by the petitioner No.1, it is reiterated that the insurers cannot act arbitrarily and unreasonably like individuals carrying on business in open market, and that they cannot discriminate among the insured persons in the matter of renewal of policies. It was contended that if the insurers refuse to renew the policy on the ground that the insured had acquired a disease, the very object of the mediclaim insurance policy would be frustrated. It was also contended that the action of the respondents in increasing the premium was arbitrary and violative of the fundamental rights of the insured guaranteed by Article 14 of the Constitution.

The decision under appeal :

7. The learned Single Judge, by a common judgement in the matters from which the Letters Patent Appeals arise, held that the action of the insurance company of declining to renew the mediclaim policy on the ground that the insured had suffered sickness when the policy was subsisting, would be wholly unreasonable and arbitrary. It was held that, in a given case, insured may be healthy at the time when the policy is taken for the first time, but thereafter he may suffer a disease for the reasons beyond his control and the treatment of such disease may continue for a period exceeding the expiry of the period of insurance, and in such circumstances, the stand taken by the insurance company to deny the renewal of the policy for such disease can be said to be unjust, unfair and arbitrary. Relying upon the decision of the Supreme Court in Biman Krishna Bose (supra), the learned single Judge held that, in view of the said decision, it cannot be said that, in the matter

of mediclaim policy, the Court, while exercising its jurisdiction under Article 226 of the Constitution, cannot direct the insurance company to renew the mediclaim policy if it finds that the action of refusal or denial to renew the policy was arbitrary and unfair. Relying upon the decision of the Supreme Court in L.I.C. of India v. Consumer Education & Research Centre, reported in (1999)5 SCC 487, the learned Single Judge rejected the contention raised on behalf of the insurance companies that they cannot be compelled to renew the policy and to continue with their insurance since the subject falls within the realm of contract. It was further held that the attempt on behalf of the insurance companies to dilute the effect of the judgement of the Apex Court in Biman Krishna Bose (supra) was misconceived, because, the Apex Court had examined the matter and the action of the insurance company of refusing to renew the mediclaim policy on the touch-stone of Article 14 of the Constitution of India. It was held that the distinction sought to be made on behalf of the insurers on the ground that the monopoly of insurance business which was with them was now removed since 1999, was ill-founded. It was held that these instrumentalities of the State were duty bound to act in a just and fair manner as mandated by Article 14 of the Constitution.

7.1 The learned Single Judge, in Special Civil Application No.11844 of 2002, directed the insurer to renew the mediclaim policy of the petitioner with effect from 4th October 2002 after collecting necessary premium including the rise in the premium as decided by the insurance company, without excluding the diseases of Heart, T.B. and Kidney failure.

7.1.1 In Special Civil Application NO.1128 of 2002, the learned Single Judge directed the insurance company to renew the mediclaim policy of the petitioner from 15-12-2002 after collecting the necessary premium without excluding the sickness of heart.

Contentions and Case Law :

8. It was contended by the learned counsel for the Appellant appearing in Letters Patent Appeal No.1028 of 2003 that there was no duty on the part of the insurance company to provide mediclaim insurance unlike insurance of motor vehicles which was statutorily required. It was argued that, in view of the stipulation contained in Clause 5.9 of the policy, the mediclaim policy could be renewed only by mutual consent and such a policy could be

cancelled by giving a thirty days' notice. There was, therefore, no right to get the policy renewed, vested in the insured. It was contended that the mediclaim policy was not a statutory policy and there was no legal or statutory right in the insured to seek continuance of such policy, nor any statutory obligation on the part of the insurer to issue or to renew such policy. Therefore, the insurance company can refuse to issue or renew such policy depending on its volition. It was submitted that the decision of the Supreme Court in Biman Krishna Bose (supra) was not applicable to the present case, because, it was held therein that renewal cannot be refused on extraneous or irrelevant consideration. The said ratio of that decision was laid down in the context of the monopoly of general insurance business with the nationalized companies that existed at that time, on the basis of which, it was held that they were having trappings of "State". It was contended that since the monopoly of these insurance companies and general insurance business statutorily ceased in 1999, in view of the amendment in the Act of 1972 by insertion of Section 24A, they ceased to have trappings of State, and that the decision in Biman Krishna Bose (supra) would no longer apply to such companies.

8.1 It was submitted that the decision of the Supreme Court in General Assurance Society Ltd. v. Chandmull Jain (supra), which was rendered by a Larger Bench, was applicable and therefore, as per the ratio of that decision, right to terminate the policy at will cannot by reason of the circumstances be read as a right to terminate for a reasonable cause. It was submitted that the insurance companies were not `State' within the meaning of Article 12 of the Constitution and since there was no right on the part of the insured to get the insurance renewed, there was no corresponding duty on the part of the insurer to renew the policy. It was then argued that the insurance could be taken only of an unforeseen event and that is why, once the disease is contracted by the insured, there cannot be any further insurance of such known event and therefore, renewal could be refused in respect of such disease. It was submitted that, if any right to renew the policy is conceded in favour of the insured, the policy would no longer remain an annual contract, but would become a permanent policy, which was not intended under the mediclaim insurance scheme.

8.2 In support of his contentions, the learned counsel relied upon the following decisions :

[a] The decision of the Supreme Court in General Assurance Society v. Chandmull Jain, reported in AIR 1966 SC 1644, was cited for the proposition that, in interpreting documents relating to a contract of insurance, the duty of the Court is to interpret the words in which the contract is expressed by the parties. It was held that where the parties agree upon certain terms which are to regulate their relationship, it is not for the Court to make a new contract, however reasonable, if the parties have not made it for themselves. A condition in an insurance policy giving mutual rights to parties to terminate the insurance at any time is a common condition in policies and must be accepted as reasonable and the right to terminate at will, cannot by reason of the circumstances be read as a right to terminate for a reasonable cause. In that case, a proposal was submitted with a view to insure certain houses against fire, including loss or damage by cyclone, flood or change of course of river or erosion of river, landslide and subsidence. The period of insurance was to be from June 3, 1950 to June 2, 1951, the company accepted the proposals by letters dated June 3, 1950 stating that, in accordance with the proposals, the insured was covered under the cover-notes enclosed with the letters. It was stipulated that the protection note cannot under any circumstances be applicable for a longer period than thirty days, and that, it is also immediately terminated, before that date by delivery of the policy, or, if the risk be declined by the notification of such declinature. On July 6, 1950, the company wrote to the assured that, in accordance with the inspection report lodged with the company, the risk was cancelled from 6th July 1950. The cover note, thus, came to be cancelled from 6th July 1950. In reply, a stand was taken up by the insured that the risk had already commenced and there could be no cancelation. The company had relied upon condition No.10 of the fire policy which enabled it to terminate at the request of the insured or at an option of the Society, on notice to that effect being given to the insured. A suit came to be filed thereafter against the society which was dismissed, but in appeal, the claim was decreed. The Division Bench of the High Court held in appeal that the standard fire policy applied condition No.10 to fire risk and not to

risk by flood, cyclone etc. It was held that condition No.10 which gave a right to either party to terminate the policy at will, could not be considered a usual condition. One of the questions that came to be considered by the Apex Court was whether the cancellation of policy was valid in law. The Supreme Court held that the cover notes were integral part of the acceptance of the proposals and the two had to be read together. When the cover-note incorporates the policy, it does not have to recite the terms and conditions, but merely to refer to a particular standard policy. The Supreme Court held that, as a matter of pure principle, there was nothing wrong in including a mutual condition for cancellation of the insurance. It was held that cancellation was reasonably possible before the liability under the policy had commenced or had become inevitable and it was a question of fact in each case whether the cancellation was legitimate or illegitimate (para 20). As regards the condition No.10, it was held that the said condition was intended to cancel the risk but not to avoid liability for loss which had taken place or to avoid risk which was already turning into loss. On the facts, it was held that it could not be said that the loss had commenced or that it had become so certain as to be inevitable or that the cancellation was done in anticipation and with knowledge of inevitable loss. The cancellation was done at a time when no one could say with any degree of certainty that the houses were in such danger, that the loss had commenced or had become inevitable. It was held that there was no evidence to establish this. It would be clear from the judgement that no question of any renewal option being exercised by the insured, as in the case of mediclaim policy, was involved in that decision.

[b] The decision of the Supreme Court in Biman Krishna Bose v. United India Insurance Co. Ltd., reported in (2001)6 SCC 477, was referred for the purpose of distinguishing it on the ground that the refusal to renew in that case was on irrelevant considerations and further that the decision was rendered at the time when there was monopoly with the insurance companies in respect of general insurance business in India. The Supreme Court held that, a renewal of an insurance policy means repetition of the original

policy and when renewed, the policy is extended, and the renewed policy in identical terms from a different date of its expiration comes into force. It was held that, if a view was taken that the mediclaim policy cannot be renewed with retrospective effect, it would give a handle to the insurance company to refuse the renewal of the policy on extraneous or irrelevant considerations and thereby, deprive the claim of the insured for treatment of diseases which have appeared during the relevant time, and further, deprive the insured for all time to come to cover those diseases under an insurance policy by virtue of the exclusion clause. It was held that, once it is found that the act of the insurance company was arbitrary in refusing to renew the policy, the policy is required to be renewed with effect from the date when it fell due for its renewal.

[c] The decision of the Supreme Court in H.H. Maharani Shantadevi P. Gaekwad v. Savajibhai Haribhai Patel, reported in 42(3) GLR 2097 was cited for the proposition that, under general law of contracts, any clause giving absolute power to one party to cancel the contract does not amount to interfering with the integrity of the contract. It was held that a contract cannot be held to be void only on this ground and such a broad proposition of law that a term in a contract giving absolute right to the parties to cancel the contract is itself enough to void it, cannot be accepted.

9. The learned counsel appearing in Letters Patent Appeals No. 1003 of 2003 and No.1004 of 2003, adopting the above contentions, further added that insurance was a contingent contract and when a disease is already contracted, there remains no future contingency and therefore, there is no question of covering insurance in respect of a disease already known to exist. It was submitted that renewal being a fresh contract, any disease which is contracted during the period of the existing policy, would be a pre-existing disease at the time of renewal of such policy. It was also contended that if the insurance company is required to continue insurance in such case, it would virtually amount to paying an annuity to the insured. It was also argued that the insurance company has a right to refuse the issuance of policy at the initial stage and also to refuse to renew the policy without any reason. It was

submitted that, under a mediclaim policy, the insurer is bound to cover the disease suffered during the currency of the policy, but the insurer has a right to refuse to underwrite business for that disease or refuse renewal, having regard to the nature of the disease. It was submitted that the insurance company was required to reduce its losses and in order to render better services to the common men, they are required to draw a line which is a matter that enters into the business sagacity and convenience of the insurance company. The Courts, therefore, cannot regulate such decisions of the insurance companies. It was submitted that, on the facts of the case, the insurance company was justified and within its contractual rights to refuse renewal in both the cases.

9.1 The learned counsel relied upon the following decisions in support of his contentions :

[a] The decision of a Division Bench of this Court in Life Insurance Corporation of India v. Asha Goel, reported in 42(3) GLR 1990 was cited for the proposition that, ordinarily the High Court should not entertain a writ petition filed under Article 226 of the Constitution for mere enforcement of a claim under a contract of insurance. It was held that where an insurer has repudiated the claim, in case such a writ petition is filed, the High Court has to consider the facts and circumstances of the case, the nature of the dispute raised and the nature of the inquiry necessary to be made for determination of the questions raised and other relevant factors before taking a decision whether it should entertain the writ petition or reject it as not maintainable. The court held that where the claim by an insured or a nominee is repudiated raising a serious dispute and the courts find the dispute to be a bonafide one which requires oral and documentary evidence for its determination, then the appropriate remedy would be a civil suit and not a writ petition.

[b] The decision of the Division Bench of this Court in Special Civil Application NO. 3628 of 1993, rendered on 31st July 1995 was relied upon for the proposition that an insurance is a contract between two parties and it is not possible for a court exercising its jurisdiction under Article 226 of the Constitution to compel the State or a statutory authority to enter into a contract

unless and until, by law, they are required to do so. In that case, the insurance cover was sought in respect of an ailment (mental retardation) which was excluded and the argument was that along with the other ailments which were included under the mediclaim insurance scheme, even such ailment should included and insurance cover be provided to those who contract such disease. The Division Bench held that, apart from the fact that the mediclaim scheme did not expressly include the case of a mentally retarded person, it was to be borne in mind that the insurance company may legitimately contend that the mentally retarded person will not take due care and caution against the contracting of illness which a normal person would take, and in these circumstances, the insurance companies would not regard this as a prudent business risk to take. Moreover, it was a matter of policy and the Court would not direct the State to frame the policy in a particular way.

[c] Reliance was placed on the decision of the High Court of Karnataka in case of B. Krishna Bhat rendered on 30th July 2002, in which also, following their earlier decision, it was held that, an insurance was a contract between two parties and it was neither required and nor was it desirable for a court to direct the State or any other authority to enter into a contract against their interests unless by law they are required to do so. The Court held that the terms of policy of insurance and its conditions are "the contractual prerogatives of an insurance company" and there is no legal provision which can compel or make it obligatory for an insurance company to make mediclaim insurance coverage to the persons suffering from a particular disease. In that case, a direction was prayed for to evolve a scheme for benefit of senior citizens and against the refusal to cover persons above the age of 75 years under the mediclaim policy, and, in that context, it was held that it was a prerogative of the insurer to contract, undertake the risk and fix the terms and conditions of the policy. The same High Court had, in writ petition No. 32804 of 1996, by its judgement and order dated 21st November 2000, dealing with a prayer where mediclaim insurance cover was sought for epilepsy held that such a course was not discriminatory and relied upon the decision of

this Court in Special Civil Application No. 3628 of 1995 decided on 31st July 1995, the ratio of which is re-produced hereinabove.

10. The learned Advocate General appearing for the insurers (respondents in Special civil Application No. 9425 of 2002) contended that insurance business was no more concentrated in the hands of the nationalized insurance companies and therefore, the aspects which have a bearing on social security, such as, emanating from Article 47 of the Constitution read with Article 21, may not be germane for the decision of this case. It was submitted that the exclusive privilege of these insurance companies in the field of general insurance business was given a go-bye and though all the companies were government companies, they were bound to act in accordance with business principles even in the field of healthcare policy. It was contended that the statute contemplated issuance of individual insurance policy and there was no statutorily prescribed insurance policy and therefore, these insurance companies were free to do their business in accordance with their business principles. It was submitted that offering a renewal clause in the policy was itself a sound business proposition so that business would not get diverted to other companies after the initial cover is taken. It was argued that every policy was an annual policy and at the time of renewal, some exercise was required to be undertaken. Therefore, renewal was not automatic. Whether renewal should be given or not, would depend upon the experience gained with the insured and if the insurer finds that it is not good to continue business with the insured, when it becomes burdensome, the insurer can stop it and refuse to renew such a policy. It was further contended that if a particular policy appears to be commercially unviable and is becoming burdensome in view of the frequency of claims, in the context of premium paid, the viability in respect of such individual policy can be examined by the insurance company for deciding whether to renew the cover or not, and the Courts can have no say in such matters. It was submitted that there was no inconsistency between the provision of Clause 11 of the prospectus, at Annexure "J" to the petition, which enabled the insured to get the policy renewed by payment of renewal premium in time, because, the offer of renewal therein was in the nature of soliciting business and did not preclude the insurer from considering the question of renewal when such premium was tendered. The insurance company can keep on renewing the cover until the policy becomes a burden. It was submitted that Clause 11 of the prospectus being intended to attract more business, there

was no conflict between that clause and clause 5.9 of the insurance policy under which renewal depended on mutual consent of the parties. It was also submitted that renewal was a fresh contract and therefore, if any disease occurred during the period of existing policy, renewal could be refused on the ground that the disease was pre-existing in the context of the renewal of the policy. It was finally contended that the right to terminate the policy or refuse renewal was an absolute right under the Cancellation Clause No. 14 of the prospectus, which corresponded to Clause 5.9 of the policy.

10.1 In support of his submissions, the learned counsel relied upon the following decisions :

[a] The decision of the Supreme Court in State of Tamil Nadu v. M/s Hind Stone, reported in AIR 1981 SC 711, was cited for the proposition, laid down in the context of renewal of a lease, that, an application for renewal was in essence an application for the grant of a lease for a fresh period, and therefore, Rule 8C of the Tamil Nadu Minor Mineral Concession Rules (1959) was attracted in considering applications for renewal of leases also, rejecting the argument that it should be confined, in its application, to grant of leases in the first instance.

[b] The decision of the Supreme Court in The Central Bank of India, Ltd. Amritsar v. The Hartford Fire Insurance Co. Ltd., reported in AIR 1965 SC 1288, was cited for the proposition that it is the Court's duty to give effect to the bargain of the parties according to their intention and when that bargain is in writing, the intention is to be looked for in the words used unless they are such that one may suspect that they do not convey the intention correctly. The Court must give effect to the plain meaning of the words however it may dislike the result. In that case, the Court was concerned with the clause in the insurance policy which stated : "This Insurance may be terminated at any time at the request of the Insured. .....The Insurance may also at any time be terminated at the instance of the company". It was held that, shortly put the clause says that either party may at its will terminate the policy and no other meaning of the words used was conceivable. The policy was taken out against loss suffered by the destruction of

or damage to certain goods by fire.

[c] The decision of the Supreme Court in Tata cellular v. Union of India, reported in AIR 1996 SC 11, was cited for pointing out the principles culled out by the Supreme Court in paragraph 113 of its judgement, inter alia, to the effect that the Government must have freedom of contract and a fairplay in the joints was a necessary concomitant for an administrative body functioning in an administrative sphere or quasi-administrative sphere. It was held that the Court did not sit as a court of appeal but merely reviews the manner in which the decision was made. However, the decision must not only be tested by the application of Wednesbury principle of reasonableness but must be free from arbitrariness not affected by bias or actuated by mala fides.

[d] The decision of the Supreme Court in The State Financial Corporation v. M/s Jagdamba Oil Mills, reported in AIR 2002 SC 834, was cited for the proposition that it is not for the Courts or a third party to substitute its decision, however, more prudent, commercial or businesslike it may be, for the decision of the Corporation.

[e] The decision of the Supreme Court in Balco Employees' Union (Regd.) v. Union of India, reported in (2002)2 SCC 333, was cited for the proposition that wisdom and advisability of economic policies are ordinarily not amenable to judicial review unless it can be demonstrated that the policy is contrary to any statutory provision or the Constitution. It was held that it is not for the courts to consider relative merits of different economic policies and consider whether a wiser or better one can be evolved.

[f] The decision of the Supreme Court in National Insurance Co. Ltd. v. Seema Malhotra, reported in (2001)3 SCC 151, was cited for the proposition that, the only profit, if at all the insurance company makes, out of the insurance business is the premium paid when no accident or damage occurs. But to ask the insurance company to bear the entire loss or damages of somebody else without the company receiving a pie towards premium is contrary to the principles of equity,

though the insurance companies are made liable to third parties on account of statutory compulsions due to the initial agreement, entered between the insured and the company concerned. It was held that the essence of the insurance business is the coverage of the risk by undertaking to indemnify the insured against loss or damage, and motivation of the insurance business is that the premium would turn to be the profit of the business in case no damage occurs.

11. The learned counsel appearing for the insured persons led by the learned counsel for the petitioners in Special Civil Application No. 9425 of 2002 have contended that the mediclaim insurance policy was a beneficial policy and if the insurance premium is paid in time, as per the standing offer contained in Clause 11 of the prospectus at Anenxure "J" to that petition, and on the basis of the implied terms of the policy itself, the policy was required to be renewed and cover extended. It was submitted that the provisions regarding renewal on payment of premium in time which were implied in the stipulations of the policy in light of the offer to renew contained in Clause 11 of the prospectus, would not get nullified by the provisions regarding renewal by mutual consent and termination contained in Clause 14 of the prospectus and Clause 5.9 of the insurance policy. The learned counsel relied upon the circular-letter dated 18-12-1998, at Anenxure "I" to the petition, pointing out that disease occurring during the period of the existing policy cannot be excluded at the time of renewal even as per the understanding of the Insurers. It was also submitted that it is only when the sum insured was to be enhanced at the time of renewal that the question of mutual consent would arise, because, a disease that has occurred during the existence of the policy can be excluded from the renewed policy only to the extent of the enhancement of the sum insured and so far as the basic sum insured is concerned, no such exclusion is warranted and renewal could not have been refused on the ground that the disease was contracted during the existence of the policy. It was submitted that the insurance companies were `State' within the meaning of Article 12 of the Constitution and could not arbitrarily or unreasonably refuse renewal of the mediclaim policy or terminate the same, despite there being a clause requiring mutual consent for renewal in the policy. The learned counsel for the insured in all these matters supported the reasoning of the learned Single Judge for their argument that the policies ought to have been renewed on payment of the renewal premium in time, and

that diseases could not have been excluded, as was sought to be done by the insurers at the time of renewing the policy.

11.1 In support of their contentions, the learned counsel for the insured persons relied upon the following decisions :

[a] Decision of the Supreme Court in Som Prakash Rekhi v. Union of India, reported in AIR 1981 SC 212 was cited for the proposition that if a statutory corporation body or other authority is an instrumentality or agency of the government, it would be an authority and therefore, State within the meaning of the expression in Article 12 and be subject to the same constitutional limitations as government.

[b] The decision of the Supreme Court in L.I.C. of India v. Consumer Education and Research Centre, reported in AIR 1995 SC 1811, was cited to point out that the Supreme Court has held that when public element is involved in the activities of the Government, then there should be fairness and equality. If the State does enter into a contract, it must do so fairly without discrimination and without unfair procedure. In paragraph 20 of the judgement, the Supreme Court held that the insurance being a social security measure, it should be consistent with the constitutional animation and conscience of socio-economic justice adumbrated in the Constitution as elucidated in the earlier part of the judgement. In paragraph 17 of the judgement, it was held that medical facilities to protect the health of workers are fundamental rights to workmen. In paragraph 18 of the judgement, it was held that : "It would thus be well settled law that the Preamble Chapter of Fundamental Rights and Directive Principles accord right to livelihood as a meaningful life, social security and disablement benefits are integral schemes of socio-economic justice to the people in particular to the middle class and lower middle class and all offendable people." In context of life insurance coverage, it was held : "The appropriate life insurance policy within the paying capacity and means of the insured to pay premia is one of the social security measures envisaged under the Constitution to make right to life meaningful, worth living and right to

livelihood a means for substenance". In paragraph 22 of the judgement, it was held that the Government, therefore, cannot anchor its role as a private person. The exercise of the power or discrimination to award contract etc. must be structured by rational, relevant and non-discriminatory standards or norms. The Court held in paragraph 23 that : "Every action of the public authority or the person acting in public interest or its acts give rise to public element, should be guided by public interest. It is the exercise of the public power or action hedged with public element becomes open to challenge. If it is shown that the exercise of the power is arbitrary, unjust and unfair, it should be no answer for the State, its instrumentality, public authority or person whose acts have the insignia of public element to say that their actions are in the field of private law and they are free to prescribe any conditions or limitations in their actions as private citizens, simpliciter, do in the field of private law. Its actions must be based on some rational and relevant principles. It must not be guided by irrational or irrelevant considerations." In paragraph 46 of the judgement, the Court held : "in issuing a general life insurance policy of any type, public element is inherent in prescription of terms and conditions therein. The appellants or any person or authority in the field of insurance owe a public duty to evolve their policies, subject to such reasonable, just and fair terms and conditions accessible to all the segments of the society for insuring the lives of eligible persons." (emphasis added).

[c] The decision of the Supreme Court in Central Inland Water Transport Corporation Ltd. v. Brojo Nath Ganguly, reported in AIR 1986 SC 1571, was cited for the proposition that if there is an instrumentality or agency of the State which has assumed the garb of a Government Company as defined in Section 617 of the Companies Act, it does not follow that it thereby ceases to be an instrumentality or agency of the State. It was held that The Central Inland Water Transport Corporation Ltd. was nothing but the Government operating behind a corporate veil, carrying out a governmental activity and governmental functions of vital doubt that the Corporation is "the State" within the meaning of Article 12 of the

Constitution.

Reasoning :

12. Improvement of public health is one of the primary duties of the State under Article 47 of the Constitution of India. Protecting health of the citizens against infectious diseases, promoting better standards of healthcare and ensuring that there are adequate safeguards against financial risks connected with severe ailments would constitute key objectives of the public health policy in a welfare State. The socially and economically marginal groups in the society can hardly afford the financial burden involved in treatment of diseases. This calls for an equitable distribution of the financial burden of ill-health. Such disproportionate economic burden on the poor sections demands State intervention to ensure that private health insurance is regulated in a manner that would promote the goals of the national health policy in the context of the directive principles of securing high standards of living of the people, to improve public health and to secure that the operation of the economic system does not result in the concentration of wealth and means of production to the common detriment, as mandated by Articles 39 and 47 of the Constitution. When the government is acting through its statutory agencies, it is discharging its obligations contained in the directive principles of State policy through such arms.

12.1 The Parliament has legislative competence to make laws with respect to "Insurance" under Entry 47 of the Union List. In order to serve better needs of the economy by securing the development of general insurance business in the best interest of the community and to ensure that the operation of the economic system does not result in the concentration of wealth to the common detriment and for regulation and control of such business, the Parliament enacted the General insurance Business (Nationalization) Act, 1972 (Act of 1972) which by section 2 declared that the said Act was enacted for giving effect to the policy of the State as defined in Article 12 towards securing the principles specified in Clause (c) of Article 39 of the Constitution.

13. The entire general business in India was nationalized by the General Insurance Business (Nationalization) Act, 1972. The Government of India, through nationalization, took over the shares of 55 Indian Insurance Companies and the Undertakings of 52 Insurers carrying on general insurance business. General

Insurance Corporation of India (GIC) was formed in pursuance of Section 9(1) of the Act of 1972, and was incorporated on 22nd November 1972 under the Companies Act, 1956, as a Private Limited Company. The GIC was formed for the purpose of superintending, controlling and carrying on the business of general insurance. As soon as the GIC was formed, the Government of India transferred all the shares it held of the general insurance companies to the GIC. Simultaneously, the nationalized undertakings were transferred to the Indian insurance companies. After a process of mergers among Indian insurance companies, four companies were left as fully owned subsidiary companies of the GIC : (1) National Insurance Company Limited, (2) The New India Assurance Company Limited, (3) The Oriental Insurance Company Limited, and (4) United India Insurance Company Limited. The next landmark happened on 19th April 2000, when the Insurance Regulatory and Development Authority Act, 1999 (IRDAA) came into force. This Act also introduced amendments to Act of 1972 and the Insurance Act of 1938. By insertion of Section 24A in the Act of 1972, the exclusive privilege of the GIC and its subsidiaries carrying on general insurance in India was removed. By Section 10A inserted in the Act of 1972, by General Insurance Business (Nationalization) Amendment Act, 2002, all the shares in the capital of these Government Insurance Companies that vested in the GIC before the commencement of the said Amendment Act stood transferred to the Central Government on such date. Thus, the ownership of these companies was vested in the Government of India. The GIC was notified as the "Indian Re-Insurer" in November 2000 and through administrative instructions, its supervisory role over subsidiaries was ended. (Source : Website of General Insurance Corporation of India - http://www.gicofindia.org/ about_us.html).

14. The expression "general insurance business" as defined in Section 3(g) of the Act of 1972, means fire, marine or miscellaneous insurance business, whether carried on singly or in combination with one or more of them, but does not include capital redemption business and annuity certain business. It is unfortunate that the subject of health insurance, which is at least as important or perhaps more from the point of view of the insurer, should find its humble place under the category of "miscellaneous insurance business", when it clearly merits recognition as a special type of insurance like life insurance, and a separate legislation like the Irish Legislation of Health Insurance Act, 1994.

14.1 Section 18(1) of the Act of 1972, inter alia, provided that the functions of the General Insurance Corporation shall include the carrying on of any part of the general insurance business, if it thinks it desirable to do so, aiding, assisting and advising the acquiring companies in the matter of setting up of standards of conduct and sound practice in general insurance business and in the matter of rendering efficient service to holders of policy of general insurance, as also, issuing directions to the acquiring companies in relation to the conduct of general insurance business. By proviso inserted in sub-section (1) of Section 18 by the Amendment Act, 2002, with effect from 7th August 2002, it was provided that all the functions specified in sub-section (1) of Section 18, on and from the date of commencement of the said Amendment Act, 2002, shall be performed by the Central Government.

14.2 Under Section 24(1) of the Act of 1972, except to the extent expressly provided in this Act, on and from the appointed day, the G.I.C. and the acquiring companies had the exclusive privilege of carrying on general insurance business in India. However, by Section 24A of the Act of 1972, which was inserted with effect from 19th April 2000, the exclusive privilege of the GIC and the acquiring companies, of carrying on general insurance business in India ceased on and from the commencement of the Insurance Regulatory and Development Authority Act, 1999 (I.R.D.A.) and the GIC and the acquiring companies were, thereafter to carry on general insurance business in India in accordance with the provisions of the Insurance Act, 1938. As per the proviso added in Section 24A, with effect from 7th August 2002, the General Insurance Corporation, on and from the commencement of the general Insurance Business (Nationalization) Amendment Act, 2002 ceased to carry on general insurance business, as noted above.

14.3 In this context, it was urged before us on behalf of the insurance companies by their learned counsel that these insurance companies should now be treated on the same footing as the private companies, in the realm of the general insurance business, including health insurance contracts, with a freedom to decide whether they should or should not renew a mediclaim policy. This contention has no merit for the simple reason that despite entry of private companies in the field, these insurance companies over which the governmental control is all pervasive and are owned by the Government of India and therefore `State' within the meaning of Article 12 of the Constitution, cannot overlook the underlying object

of their formation and the constitutional obligation to act in a fair and reasonable manner without arbitrariness, in providing cover to persons in the field of general insurance.

15. Limitations have been imposed increasingly both through legislation and judicial precedents on freedom of contract to secure fairness and prevent unfair advantage, for securing social interest. Equity demands a moral conduct. In the law of insurance, legislation and judicial decisions have co-operated to limit freedom of contract. "Statutes such as valued policy laws, provisions as to warranties, and laws providing for standard policies, have taken many features of the subject out of the domain of agreement. To no small extent, under the guise of interpretation, the tendency of judicial decision is, in effect, to attach rights and liabilities to the relation of insurer and insured and thus, remove the whole subject from the category of contract." (See "Jurisprudence" by Dean Roscoe Pound, Volume I, at page 439).

16. Insurance is regulated in increasing measure by administrative supervision by statutory authorities controlling terms of policies and prescribing limits to what may be agreed upon. Legislature has conferred large powers of regulation to administrative agencies, the effect of which is to limit freedom to make contracts and prescribe guidelines or standardize contracts.

17. It is the statutory duty of these government insurance companies under Section 19 of the Act of 1972 "to carry on general insurance business" and to so function under the Act, "as to secure that general insurance business is developed to the best advantage of the community". Thus, these statutorily controlled companies which are `State' within the meaning of Article 12 of the Constitution cannot function arbitrarily in doing their general insurance business and should act in the best advantage of the community, failure in which will justify judicial intervention to keep them within the bounds of their constitutional duty to act in a reasonable and fair manner. Any action of the Government Insurance Company which is arbitrary, unfair or untenable, or adverse to the interest of the community, would, therefore, amount to breach of duties cast upon these government companies and become subject to judicial review. The contention that these government insurance companies, which are `State' under Article 12 should now be treated at par with the private insurance companies which are not `State' for the purpose of considering

whether there is breach of constitutional obligations imposed on `State', cannot, therefore, be countenanced. We, however, make it clear that these observations should not be construed to mean that the private companies doing statutorily regulated business of general insurance, particularly healthcare, have no similar obligations arising by virtue of regulatory control and the Code of Conduct / Practice that may apply to them for a fair and reasonable conduct in the field of healthcare, which predominantly involves public interest. Afterall, public health cannot be thrown to the mercy of any arbitrary freedom of private contracts, because, the very nature of contracts involving health insurance is not a matter of mere private concerns of two contracting parties, but operates in a public field where concerns of community interest have to be read in such transactions, in the regulatory field. The law in India has addressed this concern and the Tariff Advisory Committee and the IRDA have the power to issue guidelines relating to non-discrimination and control and regulation of rates, advantages, terms and conditions.

17.1 The IRDA Act of 1999 established the Authority "to protect the interests of holders of insurance policy". Under Section 14(2)(b) of the Act of 1999, the powers and functions of the Authority include, "protection of the interests of the policy - holders in matters concerning assigning of policy, nomination by policy-holders, insurable interest, settlement of insurance claim, surrender value of policy and other terms and conditions of contracts of insurance." (emphasis added). The Authority is empowered to supervise the functions of the Tariff Advisory Committee under Clause (n) of sub-section (2) of Section 14. Under Section 26, the Authority is empowered to make regulations consistent with the Act and the Rules made thereunder to carry out the purposes of the Act.

17.2 In the exercise of its powers under Section 114A(2)(zc) of the Insurance Act, 1938 read with Sections 14 and 26 of the IRDA Act, 1999, the Authority, in consultation with the Insurance Advisory Committee, has made the regulations known as "Insurance Regulatory and Development Authority (Protection of Policy Holders' Interests) Regulations, 2002. The word `cover' is defined in Regulation 2(c) so as to mean an insurance contract whether in the form of a policy or a cover note or a Certificate of Insurance or any other form prevalent in the industry to evidence the existence of an insurance contract. The word `prospectus' as defined in Regulation 2(e) means a document issued by the insurer or in its

behalf to the prospective buyers of insurance, and should contain such particulars as are mentioned in Rule 11 of Insurance Rules, 1939 and includes a brochure or leaflet serving the purpose. Such a document should also specify the type and character of riders on the main product indicating the nature of benefits flowing thereupon. Regulation 3, inter alia, provides that, notwithstanding anything mentioned in regulation 2(e), a prospectus of any insurance product shall clearly state the scope of benefits, the extent of insurance cover and in an explicit manner explain the warranties, exceptions and conditions of the insurance cover. Under Regulation 7(1), matters to be clearly stated in general insurance policy are enumerated, and they include, "policy terms, conditions and warranties", under clause (i), and, "provision for cancellation of the policy on grounds of misrepresentation, fraud, non-disclosure of material facts or non-cooperation of the insured", under clause (m). The provisions of the Act of 1999 and the nature of regulation and control exercised thereunder show that the general insurance business is not left to the exclusive domain of purely a private contract of two individuals not involving any public interest. The constitutional and statutory provisions regulate these insurance contracts and the interest of the community is kept paramount in consonance with the Directive Principles of State Policy.

17.3 The Mediclaim Insurance Scheme, which was framed by the GIC, was a Scheme approved by the Central Government. It was not a scheme floated by some private party. This is evident from circular No. 464 dated 18th July 1986 issued by the C.B.D.T. under Section 119 of the Income-tax Act, 1961, in which, there is a reference to the budget speech in the year 1986-87 of the Finance Minister in which a proposal to provide relief to self-employed persons and salary earners other than those whose medical needs were taken care of by the employers in respect of medical expenses incurred by them by allowing a deduction out of their total income, subject to limits, for any premium on medical insurance policies taken by them with the General Insurance Corporation of India, was announced. Pursuant to that, a new clause (ib) in sub-section (1) of Section 36 of the Income-tax Act, 1961, was inserted, to allow a deduction to an employer in respect of premium paid by him by cheque for insurance on the health of his employees in accordance with a scheme framed in this behalf by the General Insurance Corporation of India and approved by the Central Government. Section 80D was inserted in the Income-tax Act, 1961 to provide a deduction to an

assessee upto Rs.3,000 a year in respect of the insurance premium paid by him by cheque. In para 4.2 of the circular, it was mentioned that the scheme was being finalized separately. Accordingly, the scheme was finalized which is known as "Hospitalisation and Domicilliary Hospitalisation Benefit Policy"; (The said circular is re-produced in Chaturvedi & Pithisaria's Income-tax Law, Fifth Edition, Volume 2, at page 1944 and the scheme appears at page 3407 under Section 80D of that volume). Thereafter, Circular No. 537 dated 12th July 1989 was issued by the C.B.D.T., which is re-produced in 179 ITR (Statutes) page 1, on the subject of Deduction of Tax at Source during the financial year 1989-90 under Section 192 of the Income-tax Act, 1961 and it will be seen from para (ix) thereof that the said scheme framed by the General Insurance Corporation of India is referred to and it is stated that it was approved by the Central Government and was popularly known as "Mediclaim". We had to resort to this exercise of finding out whether this mediclaim insurance scheme was a scheme approved by the central Government, because, we did not get any assistance throughout the hearing on the genesis of the scheme and perhaps the insurance companies themselves were not aware that the scheme which was framed by the GIC was a Scheme approved by the Central Government, on an assumption that this fact could not have been deliberately withheld from the Court, if it was to their knowledge.

17.4 It is, therefore, difficult to accept the argument that the directive principles of State policy declared under Articles 39 and 47 of the Constitution would not be germane in the context of the insurance business in healthcare carried out by these Government Companies when their exclusive privilege was given a go-bye, as was sought to be contended on behalf of the insurer companies.

18. The principal contention canvassed on behalf of the insurance companies is that, under Clause 5.9 of the insurance policy, which was a term of the contract of insurance, it was made clear that the mediclaim policy can be cancelled at the option of the insurer without any reason whatsoever, and that it may not be renewed if one of the parties to the contract did not agree to the renewal. Therefore, renewal of mediclaim policy cannot be claimed as a matter of right by the insured. It was also argued that the insurance companies have to function on sound business principles and if from the experience gained, the insurer finds that it is not prudent to continue the policy of a particular insured, the insurer

can stop it. It was contended that the insurers are justified in taking a prudent commercial decision and refusing to insure a person in respect of the diseases developed by him during the operative period of the existing policy and are also justified in refusing to renew the policy.

19. This takes us to the consideration of the nature and terms of the mediclaim insurance policy. As mentioned in paragraph 3.4.46 of the 9th Five Year Plan (Vol.2), surveys carried out by the National Sample Survey Organization (N.S.S.O.) indicated that high cost of hospitalization is one of the factors leading to indebtedness especially among low and middle-income group population. Health insurance to meet the cost of hospitalization for major illness will ensure that health care costs do not become a major financial burden or cause of indebtedness among these patients or their families. "Over the last two decades several heath insurance schemes have been introduced. ..... Some of the currently operationalised insurance schemes include Mediclaim, Group Medical Insurance Scheme, Group Health Insurance Scheme, Bhavishya Arogya (Insurance for senior citizens), Senior Citizen Unit Plan, Cancer Insurance, Asha Deep and Jan Arogya Bima Policy". It was observed that the premium of health insurance may have to be adjusted on the basis of health status, age and family of the person at the time of entry into health insurance. Yearly, "no claim bonus / adjustment of the premium" could be made on the basis of previous year's hospitalization cost reimbursed by the insurance scheme. "This would be a mechanism through which the health education messages regarding the importance of remaining healthy through optimum utilization of the preventive and promotive services as well as adopting a healthy life style get reinforced by economic incentives. (See para 3.4.46 of the 9th Five Year Plan (Vol.II).

19.1 The above observations in the 9th Five Year Plan of our country clearly indicate that healthcare schemes including Mediclaim are devised to ease the financial burden of the high costs of hospitalization on the low and middle income group population. This would enable such class of persons, namely the lower and middle income group population, who are covered by such health insurance scheme to avail of a better quality of medical services which otherwise might be out of the reach of such persons. The mediclaim scheme is, therefore, not a subject of mere private concern of two contracting parties, but a result of a national concern reflected in the norms of national health policy.

20. The Government intervention for improving health of the people is a constitutional obligation as reflected from the Directive Principles of State Policy under Articles 38, 39 and 47 of the Constitution. It becomes more imperative for the Government to intervene where illnesses are very expensive to treat. Equity in healthcare would mean equity in the burden of health spending. By providing subsidized health services or health insurance, the government can militate the inequity in such cases to achieve an equitable distribution of the financial burden of ill-health and morbidity. "The Societies are concerned not just about improvements in "average health", but also, especially, about the health and economic welfare of the socially and economically marginal groups in the society". (See Health Policy Challenges for India : Private Health Insurance & Lessons from the International Experience", by Ajay Mahal).

20.1 Any tendency to undertake risk selection so as to insure low risk individuals and exclude the high risk ones from insurance via exclusion conditions would impose a heavy financial burden on the people who are prone to get sick and most in need of risk protection, and obviously work against the above constitutional perspectives. Public health insurance schemes have, therefore, to be safeguarded against such tendencies that may be disguised under a refined argument of business or commercial prudence.

21. The fact that the field of health insurance is not left to the uninhibited freedom of contract by these government insurance companies is clearly reflected from various statutory provisions. The Act of 1972 was enacted, inter alia, for securing the development of general insurance business "in the best interest of the community". The GIC was created for the purpose of superintending, controlling and carrying on business of general insurance and its functions, as noted above, include under clause (e) of Section 18(1) "issuing directions to acquiring companies in relation to conduct of general insurance business"; and under Section 19, it is obligatory on the part of the insurance companies to carry on general insurance business and to so function under the Act, "as to secure that general insurance business is developed to the best advantage of the community". Section 39(2) of the Act of 1972 empowers the Central Government to make rules, inter alia, providing for conditions, if any, subject to which the Corporation and the acquiring companies shall carry on

general insurance business. The I.R.D.A., 1999 declares one of its objects "to protect the interests of holders of insurance policies" and the powers of the authority include "protection of the interests of the policy holders" in the matters concerning, inter alia, terms and conditions of contracts of insurance, under Section 14(2)(b). The Central Government is, by Section 18(1) of the Act of 1999, empowered to issue binding directions on question of policy to the authority.

21.1 The High Powered Committee set up by the Central Government in April 1993 to examine the structure of the insurance industry and recommend changes to make it more efficient and competitive, in its report submitted on 7th January 1994, felt that the Insurance Regulatory Apparatus should be activated even in the present set up of nationalized insurance sector and recommended, inter alia, the establishment of a strong and effective regulatory authority in form of a statutory autonomous board. (See Statement of Object and Reasons of the Act of 1999).

21.2 It will be seen from the Government of India, Citizens' Charter of General Insurance Industries, which was required to be given wide publicity by the GIC and its subsidiaries that the mission declared therein was to develop the general insurance business "in the best interests of the community". The progress on implementation of the Charter upto quarter ending September 1999 showed that the GIC and the Government Companies had introduced several covers "for the weaker sections of the society at the affordable rates". (Source : htpp: // goicharters.nic.in / gic.htm).

21.3 The throwing open of the insurance sector to competition from private Indian Companies, by insertion of Section 24A in the Act of 1972, which was done by Section 32 read with the Third Schedule of the Act of 1999, did not, however, mean that the GIC or the acquiring companies ceased to be "State" within the meaning of Article 12 of the Constitution. Rightly, therefore, the learned Advocate general, with his usual fairness, did not raise the contention, which was raised by the other counsel for the insurers that these government insurance companies are not "State" within the meaning of Article 12 of the Constitution.

23. It is, therefore, clear to us that the nationalized insurance sector remains in the field and these four government insurance companies continue to be bound by their constitutional obligations attached to the

State as defined by Article 12 of the Constitution for the purpose of Parts III and IV of the Constitution. Thus, the right to equality as guaranteed by Article 14 of the constitution cannot be violated by them and they cannot act in a discriminatory manner or arbitrarily even in the matter of insurance contracts besides being under a duty to apply the directive principles laid down in Part IV of the Constitution which are fundamental in the governance of the country. We would, therefore, view the obligations of these government insurance companies under the mediclaim insurance scheme which was introduced by the GIC with prior approval of the Central Government and the terms and conditions of the cover in the above constitutional perspective and not from the angle of a purely private negotiatory contract between two individuals not involving any public interest or statutory regulation of contractual freedom.

23. The standardised prospectus of the mediclaim insurance policy, a copy of which is produced by the insurance company with its affidavit-in-reply, at Annexure "J" of Special Civil Application No. 9425 of 2002 as well as the terms and conditions of a standardized mediclaim policy which is also produced, show that the policy covers reimbursement of hospitalization / domiciliary hospitalization for illness / diseases or injury sustained. This insurance scheme also provides for (1) family discount in premium, (2) cumulative bonus and (3) cost of health check up, as per clause 1.3, with a rider that renewal of the insurance without break is essential. Clauses 4.0, 4.1 and 4.3, which deal with exclusion are relevant in the context of the present controversy, read as follows :

"4.0 The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any insured person in connection with or in respect of :

4.1 All diseases / injuries which are pre-existing when the cover incepts for the first time,

4.2 Any disease other than those stated in clause 4.3, contracted by the insured person during the first 30 days from the commencement date of the policy. This exclusion shall not however apply if in the opinion of Panel of Medical Practitioners constituted by the Company

for the purpose, the insured person could not have known of the existence of the disease or any symptoms or complaints thereof at the time of making the proposal for insurance to the Company. This condition 4.2 shall not however apply in case of the insured person having been covered under this scheme or group insurance scheme with any of the Indian Insurance companies for a continuous period of preceding 12 months without any break.

4.3 During the first year of the operation of the policy, the expenses on treatment of diseases such as Cataract, Benign, Prostatic, Hypertrophy, Hysterectomy for Menorrhagia or Fibromyema, Hernia, Hydrocele, Congential Internal Diseases, Fistula anus, Piles, Sisusitis and related disorders are not payable. If these diseases are pre-existing at the time of proposal, they will not be covered even during subsequent period of renewal too."

23.1 A bare reading of the above exclusionary provisions in the policy shows that only in respect of the diseases / injuries which are pre-existing "when the cover incepts for the first time", the liability of the company will be excluded. This would mean that the liability in respect of the disease / injury occurring during the continuance of the cover without break will remain. This becomes more evident from clause 4.2 which affirms the liability in respect of the diseases contracted by the insured during the first thirty days from the commencement of the policy where the insured person is already covered under the scheme with any of the Indian Insurance Companies for a continuous period of preceding 12 months without any break. Again, in clause 4.3, the expression "if these diseases are pre-existing at the time of proposal, they will not be covered even during subsequent period of renewal" would suggest that the liability in respect of disease other than those which are specified in the said sub-clause will arise even during the subsequent period of renewal if they are not pre-existing at the time of proposal. There is no provision for excluding the diseases, contracted during the first year of operation of the insurance cover, in the subsequent period when the cover is extended by

virtue of renewal without break. Even for the diseases specified in clause 4.3, where the liability is excluded during the first year of operation of the cover, in the subsequent period of renewal, the liability will arise if these diseases were not pre-existing at the time of proposal.

24. In the Prospectus of the mediclaim insurance scheme, at Annexure "J" to Special Civil Application No.9425 of 2002, Clause 11 which has a bearing on the aspect of renewal of the policy, reads as under :

"11. The policy is issued for a period of one year and subject to review. Continuation of insurance cover will be available if the renewal premium is paid in time. On continuation of insurance cover and timely remittance of premium insured becomes eligible to following benefits from first days after renewal :

(a) Cumulative bonus if accrued (Ref.item 9).

(b) Cost of health check-up if due (Ref. item 10).

(c) Payment of hospitalization cost for disease / illness / injury sustained even during first 30 days of renewal and first year exclusion (Ref. Deletion of 4.2 and 4.3).

Renewal of insurance cover : A further period of 7 days from the date of expiry will be permissible in exceptional cases subject to Health Certificate from Medical practitioner.

N.B.:- Any disease contracted during the period of seven days extensions will be excluded from the date of renewal in addition to other disease excluded in the expiring policy, whereas other benefits mentioned above in item 11(a), (b), (c) will be permissible."

24.1 The words "continuance of cover will be available if the renewal is paid in time" and the provision to the effect that the benefits on the continuance of cover will accrue from the first day after renewal, are clearly indicative of the fact that the only pre-condition to continuance of cover was timely payment of the renewal. The rider below this clause that "any disease contracted during the period of 7 days extensions will be excluded

from the date of renewal", would mean that if the disease is already covered under the policy and renewal premium is paid in time, such disease will continue to be covered as it was already under the existing policy.

24.2 The terms and conditions referred in the prospectus would throw light on the intention of the parties to the contract of insurance. The mediclaim insurance scheme reflected in the prospectus, as noted above, was floated by the GIC and its subsidiaries which are "State" and the renewal provision in Clause 5.9, on which much reliance was placed, is required to be read in the light of the option of renewal given to the insured as implied in the aforesaid clauses of the mediclaim policy and as expressed under Clause 11 of the prospectus.

25. Clause 5.9 of the mediclaim policy, (which is same as the Cancellation Clause No. 14 of its prospectus, (Annexure "J" of the year 2002), reads as follows :

> "5.9 The Policy may be renewed by mutual consent. The company shall not however be bound to give notice that its due for renewal and the Company may at any time cancel this Policy by sending the insured 30 days notice by registered letter at the insured's last known address and in such event the Company shall refund to the insured a pro-rata premium for unexpired period of insurance. The Company shall, however, remain liable for any claim which arose prior to the date of cancellation. The Insured may at any time cancel this policy and in such event the company shall allow refund of premium at Company's short period rate only (table given herebelow) provided no claim has occurred upto the date of cancellation."

26. The insurer, under para 1.1 of the policy, had undertaken that "If during the continuance of this policy by renewal, any insured person shall contract any diseases or suffer from any illness ..... The Company will pay to the insured person the amount of such expenses as are reasonably and necessarily incurred. .....". This stipulation clearly indicates that the policy would be continued by renewal in respect of the diseases covered by it. The provisions in Clause 7.0 relating to "cumulative bonus" stipulating that the sum insured under the policy shall be progressively increased by 5% in respect of each claim free year of insurance

subject to the maximum of ten years and in Clause 7.1 that, in case of claim under the policy in respect of the insured person who has earned the cumulative bonus, the increased percentage will be reduced by 10% of the sum insured at the next renewal, and that, basic sum will not be reduced, are indicative of the intention of the parties including the insurer to treat the policy without break as a continuance of cover so long as the premium amount is paid, as held out in the above clauses of the policy and more explicitly in clause 11 of the prospectus, reference to which would immediately avoid the ambiguity that is sought to be introduced by reading the stipulation of renewal by consent in clause 5.9 as giving an absolute right to the insured to refuse renewal which is not in tune with the said clauses 1.1, 4.1, 4.2, 4.3, 7.0 and 7.1 of the mediclaim insurance policy.

27. Following aspects clearly emerge from the above Clauses 1.1, 4.1, 4.2, 4.3 and 7 of the mediclaim insurance policy and Clause 11 of the prospectus of the mediclaim insurance policy that : (i) the cover for the diseases which are not excluded from the first year of the cover would continue even in the renewal years if the renewal premium was paid in time; (ii) even if the insured contracts any disease which is not excluded from the existing cover, it will be continued to be covered in the subsequent year, if the renewal premium is paid in time; (iii) the disease covered under the policy will not be excluded during the continuance of the cover.

Afortiori, the renewal could not be refused if insured paid the renewal premium in time.

28. The expression "policy may be renewed by mutual consent" and "the company may at any time cancel this policy" occurring in Clause 5.9 of the policy and Clause 14 of its prospectus cannot be resorted to by these government companies for urging that they can arbitrarily put an end to the mediclaim policy or arbitrarily refuse to accept renewal premium which is tendered in time. These government companies being "State" under Article 12 are under a constitutional obligation to act reasonably and without any arbitrariness even in the matter of contract. The stipulation regarding renewal by mutual consent will, therefore, apply to cases where the government insurance company is not obliged under the existing policy to continue the cover on payment of the renewal premium in time. The disease covered by the insurance during the continuance of the policy by renewal can never by itself become the ground for refusing renewal when the disease surfaces and creates the

obligation to the extent of the sum insured under the cover which cover is required, as per the stipulation, "to be continued on payment of the renewal premium in time". Happening of the event which may give rise to a claim under the policy cannot be a ground for cancelling the cover. A party to the contract cannot disown the liability under the contract by cancelling it. The insurer is under a duty to accept the renewal premium paid in time because of the standing offer to renew implied in various clauses of the policy and expressly stipulated under Clause 11 of the prospectus, which standing offer can be accepted by timely payment of the renewal premium. The cancellation Clause 5.9 of the policy stating that the policy may be cancelled by giving 30 days' notice will have to be read in the context of the grounds mentioned in Regulation 7(1)(m) of the Protection of Policy Holders' Interests Regulations 2002, which provides that cancellation can be made only on grounds of misrepresentation, fraud, non-disclosure of material facts or non-cooperation of the insured.

29. Prospectus issued by the insurer to the prospective buyers of insurance is required to contain such particulars as are mentioned in Rule 11 of the Insurance Rules 1939. The said Rule 11, inter alia, provides that no person shall supply or exhibit any prospectus with a view to the issuance of a policy of insurance unless such a prospectus includes (a) a description of the contingency or contingencies to be covered by insurance, and (b) a full statement of circumstances, if any, in which, rebates of premiums quoted in the prospectus or table shall be allowed on the effecting or renewal of a policy. As per Rule 3 of the Protection of Policy Holders' Interests Regulations, 2002, a prospectus of any insurance product shall clearly state the scope of benefits, the extent of insurance cover and in an explicit manner, explain the warranties, exceptions and conditions of the insurance cover. Thus, prospectus for an insurance policy is statutorily required to reflect the terms on which the insurance is offered. Therefore, the renewal clause in the prospectus of a policy under this mediclaim insurance scheme which provided that continuance of insurance cover will be available if renewal premium is paid in time, is required to be kept in mind to ascertain the intention of the parties including the insurance company and such promise is to be read while construing the aspects of renewal under clause 5.9 of the policy since it is also borne out from the other clauses namely, clauses 1.1, 1.2, 4.1, 4.2, 4.3, 7.0 and 7.1 of the policy itself, which all indicate that cover would continue on renewal premium

being paid in time; and the effect of those clauses will have to be understood in light of clause 11 of the prospectus at Annexure "J" in order avoid any ambiguity over the aspect of renewal of the policy.

30. No excuse of "prudent insurer" or "business sagacity" can be put forth for shirking the liabilities that arise by virtue of the terms of the contract of mediclaim insurance. Business prudence theory does not warrant escapement from the contractual obligations. These government insurance companies, therefore, cannot arbitrarily refuse the cover, which is required to be continued when renewal premium is paid in time, under the guise of business sagacity. Business prudence or sagacity is not a defence to commit a breach of a contractual obligation. Prudent insurer may ponder before issuing the cover at its inception and can refuse to issue the cover for valid reasons or may even stop doing business, but once the contract is entered into, the contractual rights and obligations alone matter even while "prudence" might lament for the onerous situation that may have arisen under the contract.

30.1 All the bargains of insurance covers need not result in profits. The very nature of insurance business would have instances where the diseases may or may not occur, raising liability in some of greater measure than others. While arguing that no philanthropic approach is required to be adopted, the learned counsel for the insurer overlooked that it is the terms of the renewal as understood by these government companies themselves in their prospectus that bind them and the insured were within their legal rights to insist on continuance of the cover of their mediclaim insurance on payment of the renewal premium in time and did not need to appeal to any philanthropical instincts of the insurer companies. Indeed, for those who are oblivious of their constitutional, legal and contractual duties, philanthropy would be an alien concept.

31. Frequency of claim when it arises under the cover issued under this mediclaim scheme, which the insurer is bound to honour under the contract, cannot constitute a ground for evading the liability nor can it be said that such frequency amounts to a "high moral hazard" entitling the insurer to cancel or refuse to renew the cover. Claims based on occurrence of diseases covered by the mediclaim insurance can never be considered to be having any bearing on the moral integrity of the insurer when they are genuine, and their cover cannot be treated a "high moral hazard" justifying refusal to renew, or

cancellation of the cover, as was sought to be urged.

32. The contention raised on behalf of the insurers that these insurers can refuse to renew if the continuance of the cover becomes more burdensome is against the basic rule, that the parties to a contract must either perform or offer to perform their respective promises, unless such performance is dispensed with or excused under the provisions of the Indian Contract Act or any other law. (See Section 37 of the Indian Contract Act).

32.1 There was neither express nor implied term in the contract of mediclaim insurance that, on the contract becoming more onerous or burdensome, the insurer can refuse renewal of policy despite timely tender of renewal premium by the insured. Parties to a contract are bound to perform their obligations undertaken by them and cannot claim to be excused by the mere fact that performance has subsequently become more burdensome. A party cannot be absolved from liability to perform a contract merely because the performance becomes more onerous. (See M/s Alopi Parshad and Sons, Ltd. v. Union of India, reported in AIR 1960 SC 588).

32.2 Therefore, option of renewal given to the insured being an agreed term of the mediclaim policy, if denied by any arbitrary refusal or on the ground that the contract has become more onerous or burdensome, would amount to breach of term of the contract which enabled the insured to get the policy renewed by accepting the standing offer to get it renewed contained in Clause 11 of the prospectus. If the offer to get the policy renewed by timely payment of insurance can be sent by a reminder-notice by the insurer and could be accepted by tendering the premium, there is no reason why the insured should not be in the same position to accept the offer to renew which was incorporated in Clause 11 of the prospectus of the mediclaim insurance policy and also implied in the contract of insurance under which the insurance cover was stipulated to be continued on payment of the annual premium in time and it was provided that bonus benefits would be given where the continuance of cover was claim free and without break from year to year. Hardship or inconvenience or material loss by itself would not justify repudiation of the contract on the ground that there is thereby a change in the contractual obligation to renew the cover, when the insured fulfills his obligation to pay the premium in time as stipulated. There is no impossibility of performance of the contractual obligation to renew the cover as stipulated

merely because the deal becomes less profitable or entails a loss. When renewal is given in respect of the insurance under the same policy for a number of claim free years by letting the insured pay premium in time, then performance of the obligation to renew as per the stipulation of renewal, which is clearly implied having regard to the nature and contents of the contract and so understood by the insurer itself in its prospectus and the circular letter, cannot be refused on the ground that the continuance of cover by renewal of the mediclaim insurance policy would become financially more onerous. Any arbitrary refusal to renew the cover by these government companies will be open to judicial review. Refusal would, however, be justified on the grounds such as fraud, misrepresentation, non-fulfillment of the obligations by the insured, or where the performance of obligation under the contract to renew the policy as stipulated is dispensed with or excused under the provisions of the Indian Contract Act or of any other law.

33. If the insurance company provides continuity of cover under the mediclaim policy on payment of renewal premium in time and simultaneously in the cancellation clause provides that renewal will be by mutual consent, then on a harmonious construction of the two seemingly opposite provisions, the mutual consent provision will apply only to such renewals which are not consequential upon the timely payment of premium that would entail continuity of the cover. This can be illustrated by reference to the cases where the insured may want to continue their cover, but with enhancement of the sum insured. In such cases, the question of consenting to renew the cover for the extent of enhancement of the sum insured would arise and it is in the context of such enhanced sum that the company may become justified to consider exclusion of the disease so far the enhanced sum is considered though it would be liable to continue the cover for the basic sum insured, if the renewal premium was paid in time, without seeking such enhancement. If, however, a conflict is to be read between these two provisions, namely, Clause 11 of the Standard Prospectus and Clause 5.9 of the policy, same as Clause 14 of the Prospectus, the policy will have to be construed strongly against the insurer by giving due weight to the standing offer to renew contained in the Clause 11 of the prospectus which gives proper meaning to various clauses of the policy, entitling continuance of cover on payment of renewal premium by the insured in time.

33.1 It is a settled legal position that where, after

every effort to reconcile more than two clauses of contract of insurance appear plainly in conflict, it is necessary to consider the comparative weight to be given to each of them. In such cases, one of the rules applicable to determine which clause shall prevail is that the policy should be construed strongly against the insurers. In case of ambiguities in a policy, the rule is that the policy being drafted in a language chosen by the insurers, must be taken most strongly against them. It is construed contra proferentes (Verba cartarum fortius accipiuritur contra proferentem i.e. words are to be interpreted most strongly against he who uses them), against those who offer it. The insured cannot put his own meaning upon a policy, but, where it is ambiguous, it is to be construed in the sense in which he might have reasonably understood it. If the insurers wish to escape liability under given circumstances, they must use words admitting of no possible doubt. [Lord Russel of Killowen in Provincial V. Morgan, [1933] A.C. 240, 250)].

34. In the context of the renewal clause 5.9 of the policy and clause 11 of the prospectus, it would be most significant to refer to the circular letter dated 18th December 1998, at Annexure "I" to the Special civil Application No. 9425 of 2002, which totally derails the argument canvassed on the basis of the cancellation clause in clause 5.9 of the policy to the effect that the insurer has a contractual privilege to refuse to renew even when the insured is paying renewal premium in time as stipulated in the mediclaim insurance scheme or even to cancel the cover. This circular-letter is based on the GIC's letter No. Tech/A/185/2(6) dated 30th June 1988 which clarified the position in case of renewal, if there was a claim under the expiring policy. It was emphasized that the mediclaim policies which are renewed without break in the policy period and without enhancing the "sum insured" may be renewed, including the diseases contracted during the expiry period. The circular was issued by the National Insurance Company Limited, noticing that, in certain instances, the operating offices while renewing the policies, were excluding the illness for which a claim was made by the insured under the existing policy. The circular summarizes how to deal with different situations which may arise during renewal of insurance in the following terms :

"Different situations which may arise during the renewal of insurance and how to deal with them are summarized below :-

(1) In case of renewal without a break in the period the policy will be renewed including the disease contracted during the expiring policy period.

(2) If there is a break, the fresh policy must specifically exclude the disease contracted during the expiring policy period and during the break period and it should be mentioned in the schedule of the policy specifically.

(3) If an insured is already covered under an insurance policy, say, a group mediclaim, and wants to take an individual policy, the same may be issued upto the identical sum insured on the same terms and conditions if there is no break.

(4) If a person is insured with another subsidiary and wishes to renew with us, the same should be considered only after ascertaining the claim status and exclusion under the previous policy.

In case the claim status revealed is adverse or there is a continuing illness or an impending illness, such cases should be advised to continue with the same subsidiary and should not be accepted." (emphasis added).

34.1 The circular-letter dated 18th December 1998 based on the GIC's letter of 13th June 1998 also provided norms in respect of enhancement of sum insured. One such norm is that enhancement should be allowed only at the time of renewal. Requests for enhancement of sum insured in case of persons below 60 years were to be acceded to, based on a declaration that the insured has not contracted any illness or disease if the amount of enhancement did not exceed Rs.50,000=00. In case of persons above 60 years, necessary test reports and other formalities were required. Paragraph 5(c) of the circular letter, inter alia, provided that the disease for which claim has been lodged under the previous policy and of which the insured is not completely recovered, should also be specifically excluded "so far as enhancement of sum insured is concerned".

34.2 It, therefore, clearly follows that the diseases contracted during the period of existing policy cannot be excluded on renewal of the cover so far as the basic sum insured is concerned, when the renewal premium is paid in time. However, in cases where there is a request made at

the time of renewal by the insured for enhancement of sum insured, the insured cannot, by simply paying renewal premium in time in response to the standing offer contained in the stipulation incorporated in clause 11 of the prospectus, claim cover for the enhanced amount since earlier, in respect of the amount of enhancement, there was no contract between the parties. This is why mutual consent would be required for renewal in cases where there is a request for enhancement of the sum insured made by the insured at the time of renewal. Thus, there can be cases of renewal, which do not fall under the stipulation giving option to the insured to renew under the mediclaim insurance scheme by paying renewal premium in time, in which renewal could be done only under the mutual consent clause 5.9. Even in cases where there is a stipulation as to renewal at the option of the insured, as is contained in the present mediclaim insurance scheme, the insurer's rights in relation to misrepresentation or non-disclosure are governed by the state of affairs that existed at the inception of the contract and renewal can be refused, if there are detected vitiating elements in the original contract, such as, misrepresentation, fraud or non-disclosure of material facts. Despite the grounds, which would enable the insurer to repudiate the contract being detected, the insurer may waive them and, by mutual consent, renew the policy. Thus, renewal at the option of the insured by accepting the standing offer for renewal stipulated under the scheme by payment of renewal premium in time and the renewal by mutual consent under clause 5.9 of the policy, would ordinarily operate in different fields and the option to renew the mediclaim policy given to the insured cannot be rendered meaningless by subjecting it to the consent of the insurer, except on the grounds vitiating the contract when the cover first incepts.

34.3 A policy may be issued to cover a certain risk for a definite period at a stated premium without any provision for renewal, but more usually the policy is expressed to cover first a definite period, say a year, for which the premium is acknowledged to have been received, and second, an indefinite period thereafter, so long as annual or other periodic payment shall be paid in accordance with the conditions of the policy. Policies of insurance in which there is no provision for renewal can be renewed by a new agreement between the parties. Where there is a provision for renewal, it may, as is usual in life policies, give the assured an unconditional right to renew, or as is generally the case in connection with other policies, renewal may be conditional on the assent of both the parties. (See Law of Insurance, Raoul

Colinvaux, 5th Edition, para 1-38). Even life policies may be expressed by an annual contract, which the assured has the right to renew, by payment of further premium.

34.4 In the contract of insurance, the term "renewal" is used to denote both extension of the original period of cover by the exercise of a right given to the insured by the contract to extend the period of cover without the assent of the other, and the making of a new contract through the agreement of both. It is important to distinguish the two types of renewal, since only in the former case, will vitiating elements in the original contract, such as, failure to make full disclosure affect the extension, and conversely only in the later case will a duty arise to make full disclosure, at the time of renewal. Where the insurance (e.g. life insurance) gives the assured the right to renew automatically on the payment of a further premium at the end of the first period, such renewal does not constitute a new contract. (See Chitty on Contracts, 24th Edition, para 3941 at page 707).

34.5 The health insurance contract is related to the category of life contracts. A life contract would obviously include the natural process of dying and a health insurance contract would obviously include what may be inevitable illness, which perils would be covered by the insurance. In a normal contract of life assurance as distinct from contracts intended to be for a term certain, the assured must have, at least, a right of renewal subject to reasonable conditions. A policy of health insurance is for insuring against the risk of disease. One is a policy for life while the other for a healthy life. Even in a health policy, though under an annual contract on payment of annual premium, the assured must have a right of renewal subject to reasonable conditions, because, the policy is not intended to be for a term certain, but meant to cover the risk of disease for life so long the renewal premium is paid in time, as per the renewal clause. The contract of health insurance, like that of life insurance made in consideration of an annual premium, is an insurance for a year with an irrevocable offer to renew upon payment of the agreed renewal premium.

35. In an existing contract where it is specifically provided that the insurer is not bound to give notice when the policy is due for renewal and the insured remits the renewal premium in time, the insurer cannot invoke the cancellation clause for refusing renewal, unless any one of the contingencies permitting cancellation has

occurred. There is already a standing offer seeking renewal and that is why clause 5.9 stipulates that notice of renewal need not be given by the insurer. The moment insured pays premium in time the acceptance of that offer is complete and there would be no option with the insurer to deny renewal.

35.1 When offer of renewal comes from the insurer by a renewal notice or it is there in form of a standing offer contained in the existing insurance cover or under the scheme itself as declared in the prospectus, enabling the insured to get the cover continued by paying renewal premium in time, payment of the appropriate premium would amount to acceptance of such offer so as to create a binding contract and there is no room for refusing to take the premium in such a case. Therefore, there was no scope for refusing to continue the cover when the insured of Letters Patent Appeal No. 1028 of 2003 sent the revised premium by accepting the offer made by the insurer in its letter dated 30th September 2002 stating that the policy will be renewed by paying 300% premium and requesting insured to send the revised premium.

36. The contention that once the disease occurs it ceases to be an uncertain event and therefore, there can be no insurance of the disease that occurs during the period of the existing policy mocks at the very concept of health insurance and the public welfare scheme like the mediclaim insurance scheme. At the time when the insurance cover incepts, the pre-existing diseases are not covered and therefore, their being covered during the duration of the policy at any stage so long as it is renewed, cannot be considered to be a known event existing at the time when the cover first incepts.

37. Our above reasoning, which is in the context of the mediclaim insurance scheme approved by the Central Government, floated by the GIC, and implemented by the government companies, draws its full vigour from the decision of the Hon'ble the Supreme Court in Biman Krishna Bose (supra), in which the Supreme Court, while considering the mediclaim insurance policy, holding that these insurance companies were "State" under Article 12 of the Constitution, in terms, further held in paragraph 5 of the judgement that, the renewed contract was on the same terms and conditions as that of the original policy, and that if a view was taken that the mediclaim policy cannot be renewed with retrospective effect, it would give handle to the insurance company to refuse the renewal of the policy on extraneous considerations thereby deprive the claim of the insured for treatment of

diseases which have appeared during the relevant time, and further deprive the insured, for all time to come, to cover those diseases under an insurance policy by virtue of the exclusion clause. It was held that this being the disastrous effect of wrongful refusal of renewal of the insurance policy, the mischief and harm done to the insured must be remedied. The Court held that, once it is found that the act of the insurance company was arbitrary in refusing to renew the policy, the policy is required to be renewed with effect from the date when it fell due for its renewal. Earlier, in paragraph 3 of the judgement, the Court held that, even in an area of contractual relations, the State and its instrumentalities are enjoined with the obligations to act with fairness and in doing so, can take into consideration only the relevant materials. They must not take any irrelevant and extraneous consideration while arriving at a decision. Arbitrariness should not appear in their actions or decisions. The Court agreed with the view taken by the High court that the order of the insurance company refusing to renew the mediclaim policy of the appellant was unfair and arbitrary. It is clear from the judgement that its ratio is directed against all arbitrary or unfair refusals to renew the mediclaim policy. The fact that, in the case before the Supreme Court, the ground for refusal was extraneous, will not reduce the impact of the decision from the level of setting aside any arbitrary and unfair order to merely applying it to a particular instance where refusal is on some extraneous consideration, such as, approaching the Consumer Forum.

38. It was tried to be urged on the basis of Critical Illness Insurance Policy, by the learned counsel for the insurers that, under that policy, disability of insured arising out of serious illness, such as, coronary artery surgery, cancer, renal failure, stroke etc., the policy is required to be surrendered and cancelled on payment of claim and such policy cannot be required to be renewed. It will be seen from the Revised Underlying Guidelines of the Critical Illness Insurance Policy that it is a benefit policy covering disability of the insured. The policy is meant to cover earning individuals where the insured, the company or business will be affected financially due to the occurrence of disability from the critical illness. Therefore, no parallel can be drawn from the nature of that policy for urging that renewal of mediclaim policy can be refused at the sweetwill of the insurance company even when the renewal premium is paid in time. In fact, the guideline No.4 of the said Underwriting Guidelines, which were relied upon by the

learned counsel for the insurers, incorporates a pre-condition that the insured "should be having a mediclaim policy preferably also an LIC policy". Therefore, a person suffering from such critical illness in order to cover disability is required to have a mediclaim policy which also supports the view that contracting of a disease, which is covered, during the period of existing policy cannot be a ground for arbitrary refusal of renewal when the premium is paid in time by such insured. The insurer may however be entitled to load the premium at the time of renewal if permissible under the existing contract and the relevant law prevalent in relation to charging of premiums in such cases.

Conclusions :

39. For the foregoing reasons, we conclude as under :

[1] The insured has an option under the existing mediclaim insurance policy to continue the cover by payment of renewal premium in time in respect of the sum insured.

[2] In case of renewal without break in the period, the mediclaim insurance policy will be renewed without excluding any disease already covered under the existing policy which may have been contracted during the period of the expiring policy. Renewal of mediclaim insurance policy cannot be refused on the ground that the insured had contracted disease during the period of the expiring policy so far as the basic sum insured under the existing policy is concerned.

[3] In cases where the insured seeks an enhancement of the amount of sum insured at the time of renewal, the option to renew will not extend to the amount of such enhancement and renewal in respect thereof will depend upon the mutual consent of the contracting parties.

[4] Renewal of a medical claim insurance policy cannot be refused, despite timely payment of the renewal premium, on the ground that continuance of the cover would become more onerous or burdensome for the insurer due to the insured contracting a covered disease during the period of the existing policy.

[5] The insurer may refuse renewal, even in cases

where the insured has an option to renew the policy on payment of the renewal premium in time, on the grounds, such as, misrepresentation, fraud or non-disclosure of material facts that existed at the inception of the contract and would have vitiated the insurance of the cover at its inception or non-fulfillment of obligations on the part of the insured or any other ground on which the performance of the promise under the contract is dispensed with or excused under the provisions of the Indian Contract Act or any other law or when the insurer has stopped doing business.

[6] The government insurance companies continue to be "State" within the meaning of Article 12 of the Constitution notwithstanding the entry of private companies in the field of general insurance, ending their monopoly by virtue of insertion of Section 24A in the Act of 1972, and they cannot arbitrarily cancel or refuse to renew an existing mediclaim policy.

Final Order :

40. For the foregoing reasons, we find ourselves in agreement with the reasoning and conclusions of the learned Single Judge in the impugned order from which the Letters Patent Appeals No.1028 of 2003, No.1003 of 2003 and 1004 of 2003 arise, and there being no warrant for interference with the same, all the three appeals are, therefore, dismissed with costs.

40.1 For the foregoing reasons, since the grounds given for refusing to renew the mediclaim insurance policies of petitioners Nos. 2 and 3 are arbitrary and also against the contractual terms, the Special Civil Application No.9425 of 2002 is partly allowed, by holding that the refusal of renewal of the mediclaim insurance policy of the petitioners No.2 and 3 was arbitrary and illegal, and it is directed that the respondents insurance companies will renew their respective policies from the date on which they expired, on payment of the renewal premium payable by them under the Scheme, without excluding the diseases that may have been contracted by them during the period of their existing policies for the concerned year. Rule is made absolute accordingly with costs.

[R.K.ABICHANDANI, J.]

[D.A.MEHTA, J.]

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